Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies, Occupational Therapists, Physical Therapies, Speech Therapists and Speech/Hearing Clinics

Subject: New HCFA 1500 Claim Form, Revised Prior Authorization and Billing Instructions

Date: March 27, 1992

Code: MAPB-092-024-D

Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

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I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) provides important information on the Wisconsin Medical Assistance Program's (WMAP) implementation of a new HCFA 1500 claim form and revised prior authorization and billing instructions for durable medical equipment. **It is important that providers review this information carefully and share it with billing staff.**

II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs use the revised National HCFA 1500 claim form (dated 12/90). All paper claims received by EDS from March 15, 1992, through May 1, 1992, may be submitted on either the current HCFA 1500 claim form (dated 1/84) or the new claim form.

All claims, including the resubmission of any previously denied claims, received by EDS after May 1, 1992, must be submitted on the HCFA 1500 claim form dated 12/90. Claims received by EDS after May 1, 1992, on claim forms other than the HCFA 1500 (12/90) claim form, will be denied. Modified versions of the National HCFA 1500 claim form may also be denied.

Please allow ample mailing time to ensure that claims submitted on the current HCFA 1500 claim form are received at EDS by May 1, 1992.

Crossover claims for Medicare Part B coinsurance and deductible allowed charges may be submitted on either the new or old HCFA 1500 claim form.

There are no changes to the submission of electronic claims.

A sample claim form and detailed claim form completion instructions are included in Attachments 1 and 2 of this MAPB. All claims received by EDS on the new HCFA 1500 claim form must be completed according to these instructions. The instructions in this MAPB completely replace the instructions that you received in MAPB-087-013-D/014-D/016-D dated September 1, 1987.

As you read the completion instructions in Attachment 2, please watch for the following changes:

- The procedure code is now indicated in Element 24D of the claim form, but the procedure code description is no longer required.
- The performing provider number is now required in Element K for each line item of the claim form, but the performing provider name is no longer required.
- An emergency condition must be indicated for each applicable line item on the claim form by entering an "E" in Element 24I.
- Services resulting from HealthCheck (EPSDT) referrals must be indicated for each applicable line item on the claim form by entering "H" for HealthCheck services in Element 24H.

The National HCFA 1500 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

III. PLACE OF SERVICE CODES

Until further notice, the WMAP will continue to require the single-digit place of service codes on the HCFA 1500 claim, not the two-digit place of service codes required by Medicare. Claims with Medicare Part B allowed charges that cross over to the WMAP from WPS will have the place of service codes automatically converted to single-digit codes for claims processing. However, paper crossover claims, as well as all paper and electronic claims submitted directly to the WMAP, must indicate the appropriate single-digit place of service code.

IV. CORRECTIONS TO DME INDEX

There are two changes to the DME Index issued with MAPB-023-D dated December 15, 1991. These changes are effective with claims received at EDS on or after April 1, 1992. Attachment 3 of this MAPB contains a replacement for page 3 of the DME Index. Please remove and destroy page 3 of the DME Index. Insert the replacement page.

Procedure Code E0179 has a new description: "Dry Pressure Pad or Cushion, Non-positioning (e.g., eggcarte). A new procedure code, W0905, has been created and is defined as "Bathroom Equipment, includes rails, seats, stools, benches, any type."

V. PRIOR AUTHORIZATION AND BILLING FOR SERVICES USING A NON-SPECIFIC, "NOT OTHERWISE CLASSIFIED" OR REPAIR PROCEDURE CODE

This replaces some of the information contained in MAPB-090-021-D, dated August 10, 1990.

Nonspecific procedure codes, or "not otherwise classified" codes are to be used only when there is not a distinct procedure code for the service being provided. Whenever possible, use the most specific codes available, rather than general codes such as E1399 and W6891.

The WMAP is implementing a new way to process nonspecific, "not otherwise classified," and repair procedure codes. Effective with prior authorization requests received by EDS on and after April 1, 1992, the maximum allowable reimbursement for these codes will be determined when the prior authorization is approved. Reimbursement is then the billed amount or the amount on the Prior Authorization Request Form (PA/RF), whichever is less.

This means that repair codes and nonspecific codes can be billed electronically or billed by using the revised HCFA 1500 for dates of service on or after April 1, 1992. Refer to Attachment 4 of this MAPB for the list of nonspecific codes priced under this new process.

Process for Requesting Prior Authorization and Submitting Claims for Nonspecific Codes and Repair Codes

A. Submitting a Prior Authorization Request Form (PA/RF)

1. Include a description of each item with a nonspecific procedure code in sufficient detail to enable the WMAP to set the maximum allowable reimbursement. This must include the manufacturer's item description (e.g., name and model number).

2. Do not include a modifier in element 15 unless modifier "01" is necessary to indicate a bilateral procedure. (Refer to "Receiving an Approved PA/RF" and "Billing for Nonspecific Codes" for further information on modifiers.)

3. Always indicate a quantity of "1" in element 19 for nonspecific codes. If requesting two identical items within a nonspecific code, identify this as a "pair" in the description or by using a bilateral modifier when allowed. Effective April 1, 1992, procedure codes W6849, W6891, and E1399 will no longer be authorized as bilateral services, but may be requested as a pair. If requesting a series of services, (e.g., serial splints) include the number of splints in the description and quantity of "1" in element 19. These procedure codes should be billed once per prior authorization number upon completion of service.

B. Submitting a Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). (For procedure code W6999, submit Prior Authorization Aid Request Form 1 (PA/ARF1).

Where relevant, include justification of why less expensive equipment is inappropriate for the recipient.

C. Receiving an Approved PA/RF

1. The maximum allowable reimbursement is indicated for repair and nonspecific procedure codes in element 20. This is initialed and initiated by the state consultant.

2. If several items are approved under one nonspecific code, procedure code modifiers (numbers 11-22) are assigned in element 15 to each approved item by the consultant.

D. Submitting Amendments to An Approved PA/RF

1. The only way to obtain a higher level of reimbursement than is identified on the PA/RF for nonspecific codes is by submitting a prior authorization amendment request. An amendment may be submitted if the provider can document that the approved maximum allowable reimbursement does not cover the cost of parts or repairs.

2. If an amended PA/RF is approved after you have received reimbursement, submit an adjustment request for additional reimbursement which indicates that the prior authorization maximum has been changed. Refer to Part A Section IX of the WMAP Provider Handbook for information about adjustment requests.

E. Billing for Nonspecific Codes

1. Use a quantity of "1" to bill for each detail of a nonspecific code.

2. When a modifier is assigned to a nonspecific procedure code on the approved PA/RF, the modifier must be used when billing for the specific authorized items.

3. Reimbursement is the billed amount or the amount approved on the PA/RF, whichever is less.

Refer to Attachments 5, 5a, and 1 for a sample PA/RF submission, PA/RF approval and claim.

VI. CHANGES IN PRIOR AUTHORIZATION LIMITS

A lower prior authorization dollar threshold has been established for certain custom and repair codes effective for dates of service on or after May 1, 1992. Refer to Attachment 6 for a list of these codes and the new dollar thresholds. Claims for these services which exceed the new dollar threshold and are submitted without a Prior Authorization number will be denied. Please note these changes in your DME Index issued December 15, 1991.

Reimbursement for these services which exceed the prior authorization threshold will be established through the Prior Authorization process described in Section V of this MAPB. Reimbursement for these services which fall below the threshold will be paid at a rate established by the Department of Health and Social Services.

For repair codes, providers are reminded that the dollar threshold amounts are per entire repair service. If it takes two days to repair an adaptive communication device and the completed cost exceeds the threshold, it is not appropriate to break the repair in two parts. If a provider must repair two different parts to get the adaptive communication device running again, the repair should not be billed as two repairs. For purposes of the prior authorization threshold, the WMAP considers each of these examples single repairs. The provider must indicate on the claim form the exact date or dates on which the service occurred and indicate a quantity of "1" for each repair code.

If providers need to make immediate, emergency repairs to make an adaptive communication device operating again, but the repairs will exceed the dollar threshold, they may request backdating of the Prior Authorization request. Requests for emergency Prior Authorization with backdating must be received by EDS within two weeks of the date of service, since Prior Authorizations cannot be backdated more than 14 days from receipt date. The PA/RF must clearly state the request for backdating, the reason backdating is requested, and must indicate the date of service. Procedures for requesting backdating are indicated in Section VIII - F of Part A, the All Provider Handbook.

VII. BILLING FOR UNLISTED SPEECH/HEARING CLINIC PROCEDURE CODE 92599

Claims for 92599 (unlisted otorhinolaryngological service or procedure) require documentation describing the procedure performed. The provider may use element 19 of the HCFA 1500 claim form (Reserved for Local Use), if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "see attached" in element 19 and attach additional documentation. This documentation may be in the form of a physician's prescription, history and physical exam report, or a medical progress report. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for procedure code 92599 which do not have the documentation either on the claim or attached to the claim form will be denied.

VIII. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)

The Department of Health and Social Services is currently in the process of identifying appropriate coverage and pricing policies for the new durable medical equipment procedures identified in the 1992 Current Procedural Terminology published by the American Medical Association. Providers should continue to use the allowable procedures identified in the Durable Medical Index issued December 15, 1991, as modified by this MAPB until further notice. Claims for DME procedures which were newly added to the CPT in 1992 will be denied. We anticipate that appropriate new codes will be added, effective for dates of service on or after July 1, 1992.

ATTACHMENTS

THERAPY SERVICES

1. National HCFA 1500 Claim Form Sample

2. National HCFA 1500 Claim Form Completion Instructions

3. DME Index Replacement Page

4. List of Procedures In Which Reimbursement Is Determined At Time of Prior Authorization Approval

5. Prior Authorization Request Form (PA/RF) Sample

5a. Prior Authorization Request Form (PA/RF) Approval Sample

6. List of Procedure Codes Having a Lower Prior Authorization Threshold

ATTACHMENT 1

NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1 MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [ ]
(Medicare #) [T] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)

1a INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 234567890

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3 PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [ ] F [X]

4 INSURED'S NAME (Last Name, First Name, Middle Initial):

5 PATIENT'S ADDRESS (No., Street): 609 Willow St.

6 PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7 INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8 PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: — STATE:

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10 IS PATIENT'S CONDITION RELATED TO:

11 INSURED'S POLICY GROUP OR FECA NUMBER:

a OTHER INSURED'S POLICY OR GROUP NUMBER:

a EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]

b AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b EMPLOYER'S NAME OR SCHOOL NAME:

c EMPLOYER'S NAME OR SCHOOL NAME:

c OTHER ACCIDENT? YES [ ] NO [ ]

c INSURANCE PLAN NAME OR PROGRAM NAME:

d INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY:

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY:

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring

17a I.D. NUMBER OF REFERRING PHYSICIAN: 12345678

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19 RESERVED FOR LOCAL USE:

20 OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 342.__
2. 436.__
3. ____.__
4. ____.__

22 MEDICAID RESUBMISSION CODE: — ORIGINAL REF. NO:

23 PRIOR AUTHORIZATION NUMBER: 1234567

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
03 02 92		7	1	W9529		1	XX XX	2				11223344
03 15 92	17	7	1	W9523		1	XX XX	2				11223344
03 21 92	23 29	7	1	W9523		1	XX XX	9				11223344
03 16 92				W9512		1	XX XX	1				11223344

25 FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26 PATIENT'S ACCOUNT NO: 1234JED

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28 TOTAL CHARGE: $ XXX XX

29 AMOUNT PAID: $ XX XX

30 BALANCE DUE: $ XXX XX

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
MM/DD/YY
SIGNED DATE

32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):

33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Billing
1 W. Williams
Anytown, WI 55555
PIN# — GRP# 87654321

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8 83

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12 90)
FORM OWCP-1500 FORM RRB-1500

ATTACHMENT 2

NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR THERAPY SERVICES

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "D" (Durable Medical Equipment) or "T" (Therapy Services) for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook.

When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE

When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by other insurance, in whole or in part
OI-H	DENIED by the HMO or HMP for one of the following reasons: - noncovered service - applied to deductible or copayment - family planning services (if WPS-HMP only)

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider.

When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Section IX of Part A of the WMAP Provider Handbook, this element may be left blank.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Medicare disallowed (denied) service
M-8	Not a Medicare benefit

If a recipient's Medical Assistance identification card indicates no Medicare coverage, this element may be left blank. If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of this type of claim.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
Enter the referring provider's eight-digit Medical Assistance provider number if certified by the WMAP. If the referring provider is not WMAP-certified, enter the provider's license number.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB
If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.

- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

-- All dates of service are in the same calendar month.

-- All services performed are identical.

-- All procedures have the same type of service code.

-- All procedures have the same place of service code.

-- All procedures were performed by the same provider.

-- The same diagnosis is applicable for each procedure.

-- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)

-- The number of services performed on each date of service is identical.

-- All procedures have the same HealthCheck or family planning indicator.

-- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service.

Numeric	Description
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code.

Numeric	Description
1	Medical (including: Injection, Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, Medical Day Treatment)
9	Other Services, including: Rehabilitation Agency

Alpha	Description
P	Purchase New DME
R	DME Rental

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a two-character modifier.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. When billing procedure code 99000 (lab handling fee); indicate the number of labs in this element. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck/family planning do not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

> NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

HCPCS Code	Bi-lateral	Description	Rental/ Purchase Restrict.	Prior Auth. Req.	Life Expect.	N. Home Reimb.	Co-Payment
W6849		Adaptive positioning equipment, unlisted procedure	P	*			$1.00
		HOME HEALTH EQUIPMENT					
E0179		Dry pressure pad or cushion, non-position (e.g., eggcarte)	P,R		1 year		$.50
W0905		Bathroom equipment, includes: rails, seats, stools, benches, any type	P,R	*	5 years		$2.00
E0241		Bath tub wall rail, each	P		2 per lifetime		$0.50
E0242		Bath tub rail, floor base, each	P		2 per lifetime		$0.50
E0243		Toilet rail, each	P		2 per lifetime		$0.50
E0244		Raised toilet seat	P		8 years		$1.00
E0245		Tub stool or bench	P		5 years		$1.00
E0246		Transfer tub rail attachment	P		1/lifetime		$1.00
E1399	*	Durable medical equipment, not otherwise classified (claim must specify complete description of DME)	P,R	*		R	$1.00
W6802		Bath chair (e.g. lounge-type - TLC chair)	P		8 years		$1.00
E0746		Electromyography (EMG), biofeedback device	P,R	* **	8 years		$1.00
W6814		Grab bars - each	P		8 years		$1.00
W6824		Shower hose	P		1/lifetime		$1.00
W6827		Transfer tub bench	P,R	* **	8 years	R	$1.00
W6891	*	Consultant approved - DME purchase/rental	P,R	*		R	$1.00

ATTACHMENT 3

MAPB-092-024-D
March 27, 1991

P .39.CW/B3 vg

HCPCS Code	Bi-lateral	Description	Rental/ Purchase Restrict.	Prior Auth. Req.	Life Expect.	N. Home Reimb.	Co-Payment
W6849		Adaptive positioning equipment, unlisted procedure	P	*			$1.00
		HOME HEALTH EQUIPMENT					
E0179		Dry pressure pad or cushion, non-position (e.g., eggcarte)	P,R		1 year		$.50
W0905		Bathroom equipment, includes: rails, seats, stools, benches, any type	P,R	*	5 years		$2.00
E0241		Bath tub wall rail, each	P		2 per lifetime		$0.50
E0242		Bath tub rail, floor base, each	P		2 per lifetime		$0.50
E0243		Toilet rail, each	P		2 per lifetime		$0.50
E0244		Raised toilet seat	P		8 years		$1.00
E0245		Tub stool or bench	P		5 years		$1.00
E0246		Transfer tub rail attachment	P		1/lifetime		$1.00
E1399	*	Durable medical equipment, not otherwise classified (claim must specify complete description of DME)	P,R	*		R	$1.00
W6802		Bath chair (e.g. lounge-type - TLC chair)	P		8 years		$1.00
E0746		Electromyography (EMG), biofeedback device	P,R	* **	8 years		$1.00
W6814		Grab bars - each	P		8 years		$1.00
W6824		Shower hose	P		1/lifetime		$1.00
W6827		Transfer tub bench	P,R	* **	8 years	R	$1.00
W6891	*	Consultant approved - DME purchase/rental	P,R	*		R	$1.00

ATTACHMENT 3

MAPB-092-024-D
March 27, 1991

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ATTACHMENT 4

PROCEDURE CODES IN WHICH REIMBURSEMENT
IS DETERMINED AT TIME OF PRIOR AUTHORIZATION

REHABILITATION AGENCIES

E1350	Repair or Non-Routine Service (e.g., breaking down)
E1360	Replacement, Supply or Accessory Necessary for Effective Use of Medically Necessary Equipment Owned by
E1399	Durable Medical Equipment, Not Otherwise Classified
L1499	Unlisted Procedure for Spinal Orthosis
L2999	Unlisted Procedures for Lower Extremity Orthoses
L3999	Unlisted Procedure for Upper Limb Orthosis
L4210	Repair of Orthotic Device, Repair or Replace Minor Parts
W0905	Bathroom Equipment, Includes, Rails, Seats, Stools, Benches, any Type
W6634	Orthosis, Custom, Fabricated Additions/Modifications
W6808	Communicator (Including Accessories)
W6849	Adaptive/Positioning Equipment, Not Otherwise Classified
W6891	Consultant Approved-DME Purchase Not Otherwise Classified

PHYSICAL THERAPISTS

E1360	Replacement, Supply or Accessory Necessary for Effective Use of Medically Necessary Equipment Owned by
E1399	Durable Medical Equipment, Not Otherwise Classified
L1499	Unlisted Procedure for Spinal Orthosis
L2999	Unlisted Procedures for Lower Extremity Orthoses
L3999	Unlisted Procedure for Upper Limb Orthosis
L4210	Repair of Orthotic Device, Repair or Replace Minor Parts
W6634	Orthosis, Custom, Fabricated Additions/Modifications
W6891	Consultant Approved-DME Purchase Not Otherwise Classified

OCCUPATIONAL THERAPISTS

E1360	Replacement, Supply or Accessory Necessary for Effective Use of Medically Necessary Equipment Owned by
E1399	Durable Medical Equipment, Not Otherwise Classified
L1499	Unlisted Procedure for Spinal Orthosis
L2999	Unlisted Procedures for Lower Extremity Orthoses
L3999	Unlisted Procedure for Upper Limb Orthosis
L4210	Repair of Orthotic Device, Repair or Replace Minor Parts

W0905	Bathroom Equipment, Includes, Rails, Seats, Stools, Benches, any Type
W6634	Orthosis, Custom, Fabricated Additions/Modifications
W6849	Adaptive/Positioning Equipment, Not Otherwise Classified
W6891	Consultant Approved-DME Purchase Not Otherwise Classified

SPEECH/HEARING CLINICS

E1360	Replacement, Supply or Accessory Necessary for Effective Use of Medically Necessary Equipment Owned by
E1350	Repair or Non-Routine Service (e.g., breaking down)
W6808	Communicator (Including Accessories)
W6891	Consultant Approved-DME Purchase Not Otherwise Classified
W6999	Unlisted Hearing Aid Services

SPEECH THERAPY

E1360	Replacement, Supply or Accessory Necessary for Effective Use of Medically Necessary Equipment Owned by
E1350	Repair or Non-Routine Service (e.g., breaking down)
W6808	Communicator (Including Accessories)
W6891	Consultant Approved-DME Purchase Not Otherwise Classified

ATTACHMENT 5

PRIOR AUTHORIZATION REQUEST FORM (PA/RF) SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im A

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow St.
Anytown, WI 55555

5 DATE OF BIRTH
MM/DD/YY

6 SEX
M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX)XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
V537

11 DX: SECONDARY

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6635		3	P	Ischial containment/narrow M-L socket for knee disarticulation	1	XXXX.XX
W6635		3	P	Ultra-light materials for KD	1	XXXX.XX
W6635		3	P	Energy-storing foot	1	XXX.XX
					TOTAL CHARGE	21 XXXX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I.M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION

[ ] APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON

DATE

CONSULTANT ANALYST SIGNATURE

ATTACHMENT 5a

PRIOR AUTHORIZATION REQUEST FORM (PA/RF) APPROVAL SAMPLE

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 130

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX)XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Billing
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 12345678

10 DX: PRIMARY: V537

11 DX: SECONDARY:

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W6635	11	3	P	Ischial containment/narrow M-L socket for knee disarticulation	1	med. cons. initials Price ~~XXXX.XX~~
W6635	12	3	P	Ultra-light materials for KD	1	med. cons. initials Price ~~XXXX.XX~~
W6635	13	3	P	Energy-storing foot	1	med. cons. initials Price ~~XXX.XX~~
					TOTAL CHARGE	21 med. cons. initials Price ~~XXXX.XX~~

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I.M. Requesting (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[☑] APPROVED — mm/DD/YY (GRANT DATE) — mm/DD/YY (EXPIRATION DATE) — PROCEDURE(S) AUTHORIZED as modified and priced above — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

mm/DD/YY (DATE)

I.M. Consultant (CONSULTANT ANALYST SIGNATURE)

ATTACHMENT 6

HAVING A LOWER PRIOR AUTHORIZATION THRESHOLD
Prior Authorization required if billed amount equals or exceeds $150
for dates of services on or after May 1, 1992

REHABILITATION AGENCIES

E1350	Repair of Non-Routine Service (e.g., breaking down)
L4210	Repair of Orthotic Device, Repair or Replace Minor Parts
W6634	Orthosis, Custom, Fabricated Additions/Modifications

PHYSICAL THERAPISTS

L4210	Repair of Orthotic Device, Repair or Replace Minor Parts
W6634	Orthosis, Custom, Fabricated Additions/Modifications

OCCUPATIONAL THERAPISTS

L4210	Repair of Orthotic Device, Repair or Replace Minor Parts
W6634	Orthosis, Custom, Fabricated Additions/Modifications

SPEECH/HEARING CLINICS

E1350	Repair of Non-Routine Service (e.g., breaking down)

SPEECH THERAPY

E1350	Repair of Non-Routine Service (e.g., breaking down)